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No. 88-2043

In The

Supreme Court of the United States

October Term, 1989

GERALD L. BALILES, *et al.*,

Petitioners,

v.

THE VIRGINIA HOSPITAL ASSOCIATION,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

JOINT APPENDIX

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May 31, 1988 – Defendants' Petition for Permission to Appeal Filed in Court of Appeals

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IN THE UNITED STATES DISTRICT
FOR THE EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

THE VIRGINIA HOSPITAL ASSOCIATION,
A Virginia Non-Stock Corporation,
On Behalf Of Its Member Hospitals
And all Others Similarly Situated,

Plaintiff,

v. Civil Action No.: 86-0166-R

GERALD L. BALILES,
Governor of the
Commonwealth of Virginia,

EVA S. TEIG,
Secretary of Human Resources
of the Commonwealth of Virginia,

RAY T. SORRELL,
Director of Medical
Assistance Services,

MS. BETTE O. KANTER
Member, State Board of
Medical Assistance Services,

MR. JOSEPH M. TEEFY
Member, State Board of
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Member, State Board of
Medical Assistance Services,

and

MR. JOHN N. SIMPSON
Member, State Board of
Medical Assistance Services,

Defendants.

AMENDED COMPLAINT

I. PRELIMINARY STATEMENT

A. *Introduction*

1. This action arises under the federal social security laws and the United States Constitution. The federal statutory claims arise under Title XIX of the Social Security Act, 42 U.S.C. § 1396, *et seq.* (hereinafter referred to as "Medicaid Act"). The constitutional claims arise under the Supremacy Clause, Article 6, Section 2 and the Due Process Clause of the Fourteenth Amendment. The plaintiff herein seeks declaratory and injunctive relief from the application of the Virginia State Plan under Title XIX of

the Social Security Act, Attachment 4.19-A, "Methods and Standards for Establishing Payment Rates – In-patient Care" (hereinafter the "Medicaid Payment Program") and the "Final Regulations for Hospital Appeals of Reimbursement Rates" (hereinafter the "Appeals Regulations"), as amended, because the Virginia State Plan directly conflicts with the Medicaid Act's conditions for participation by states in Medicaid and denies hospitals due process of law in the establishment, payment and appeal of Medicaid reimbursement rates, in that said rates are not reasonable and adequate to meet the economically and efficiently incurred cost of providing care to Medicaid patients in hospitals and do not assure access to inpatient care, all as is required under the Medicaid Act and as is more fully set forth below.

B. *Jurisdiction*

2. This case arises under the Constitution and laws of the United States, including, but without limitation thereof, 42 U.S.C. § 1983 and 28 U.S.C. §§ 2201 *et seq.* Jurisdiction over this case is conferred upon this Court by 28 U.S.C. § 1331 and 28 U.S.C. § 1343 which provide for jurisdiction over federal questions and suits arising under 42 U.S.C. § 1983, respectively. The amount in controversy exceeds Ten Thousand Dollars ($10,000.00), exclusive of interest and costs.

C. *Parties*

3. The Virginia Hospital Association (hereinafter "VHA") is a Virginia non-stock, not-for-profit corporation duly incorporated under the laws of the Commonwealth of Virginia for the purpose of developing and improving the hospital industry in Virginia. Its members include

both public and private hospitals operating in Virginia. The private hospitals are operated on both non-profit and profit bases. The member hospitals of the Virginia Hospital Association constitute the vast majority, some 90%, of all hospitals which participate in and receive payments under the Virginia Medicaid Payment Program. The VHA has the authority and the duty as a trade association to represent the financial interests of its members in obtaining reasonable and adequate payment for treatment of Medicaid beneficiaries. The issues of fact and law involved in this action are common to all Virginia Medicaid hospitals, joinder of all such hospitals is impracticable, and the VHA can adequately represent such hospitals on these common claims without requiring the participation of individual hospitals.

4. The Defendant Gerald L. Baliles is the Governor of the Commonwealth of Virginia and is charged with approving all amendments to the Virginia State Plan for Medical Assistance (hereinafter referred to as the "State Plan"). His predecessor did approve the submission of the Medicaid Payment Program as an amendment to the State Plan, and he has continued such approval, including approval, either directly, of indirectly of the Appeal Regulations as an amendment to Attachment 4.19-A and the State Plan. The Governor is named in his official capacity.

5. The Defendant Eva S. Teig is Secretary of Human Resources of the Commonwealth of Virginia and is charged with directing the actions of the Director of Medical Assistance Services. The Secretary's predecessor supervised the adoption of the Medicaid Payment Program and approved it as an amendment to the State Plan.

She has continued such supervision and approval, either directly or indirectly including approval of the Appeal Regulations as an amendment to Attachment 4.19-A and the State Plan. The Secretary is named in her official capacity.

6. The Defendant Ray T. Sorrell is the Director of Medical Assistance Services of the Commonwealth of Virginia. He is Secretary of the State Board of Medical Assistance Services and is charged with the direction of the Department of Medical Assistance Services (hereinafter "DMAS"). In such capacity, he is primarily responsible for the drafting and promulgation of the State Plan and any amendments thereto. His and DMAS's predecessors promulgated the Medicaid Payment Program as an amendment to the State Plan. He has promulgated the Appeal Regulations as an amendment to Attachment 4.19-A and the State Plan and has continued the Medicaid Payment Program's operation. Mr. Sorrell is also charged with the duty to administer the State Plan and to receive and expend federal funds thereof in accordance with applicable federal and state laws and regulations. The Director is named in his official capacity.

7. The Defendants Ms. Bette O. Kanter, Mr. Joseph M. Teefy, Mr. R. Michael Berryman, Ford Tucker Johnson, Sr., D.D.S., A. Epes Harris, Jr., M.D., Ms. Ruth Hanft, Patricia E. Sloan, R.N., Ed.D., Mr. Jordan H. Goldman, Mr. Robert B. Lambeth, Jr. Ms. Elsa A. Porter, and Mr. John N. Simpson, are members of the State Board of Medical Assistance Services (hereinafter referred to as the "Board"). The Board, subject to the approval of the Governor is authorized to prepare, amend and submit to the Secretary of the United States Department of Health and

Human Services the State Plan pursuant to Title XIX of the United States Social Security Act, and any amendments thereto. Pursuant to such authority, the Board's predecessor promulgated and adopted the Medicaid Payment Program, and the Board has continued that Program's operation. The Board has also promulgated and adopted the Appeal Regulations as an amendment to Attachment 4.19-A and the State Plan.

II. *STATEMENT OF THE CLAIM*

8. The Medicaid Act provides basic protection against costs of hospital and other health care services to certain indigent persons through payments by the federal government to states which elect to participate in Medicaid. As a condition of participation, each state must submit and receive approval on their state plans for medical assistance from the Secretary of Health and Human Services.

9. Pursuant to the Medicaid Act, 42 U.S.C. § 1396a(a)(13), a state plan for medical assistance must provide:

> "(A) for payment . . . of the hospital . . . services provided under the plan through the use of rates . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to in-patient hospital services of adequate quality. . . ."

10. Pursuant to the Medicaid Act, the Secretary of the Department of Health and Human Services promulgated regulations regarding state plans which provide as follows:

"Subpart C – Payment for Inpatient Hospital and Long-Term Care Facility Services.

§ 447.250. Basis and purpose.

This subpart implements section 1902(a)(13)(A) of the Act, which requires that the State plan provide for payment for hospital and long-term care facility services through the use of rates that the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with State and Federal laws, regulations, and quality and safety standards.

* * *

§ 447.252 State plan requirements.

(a) The plan must provide that the requirements of this subpart are met.

(b) The plan must specify comprehensively the methods and standards used by the agency to set payment rates in a manner consistent with 45 CFR 201.2.

(c) If the agency chooses to apply the cost limits established under Medicare (see § 413.30 of this chapter) on an individual provider basis, the plan must specify this requirement.

* * *

§ 447.253 Other requirements.

(a) *State assurances.* In order to receive HCFA approval of a State plan change in payment methods and standards, the Medicaid agency must make assurances satisfactory to HCFA that the requirements set forth in paragraphs (b) through (g) of this section are being met, must submit the related information required by § 447.255 of this subpart, and must comply with all other requirements of this subpart.

(b) *Findings.* Whenever the Medicaid agency makes a change in its methods and standards, but not less often than annually, the agency must make the following findings:

(1) *Payment rates.* (i) The Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

(ii) With respect to inpatient hospitals services –

(A) The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs;

(B) If a State elects in its State plan to cover inappropriate level of care services . . . ,

the methods and standards used to determine payment rates must specify that the payments for this type of care must be made at rates lower than those for inpatient hospital level of care services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G); and

(C) The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

(2) *Upper payment limits*. The agency's proposed payment rate will not exceed the upper payment limits as specified in § 447.272.

(c) *Provider appeals*. The Medicaid agency must provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates.

(d) *Uniform cost reporting*. The Medicaid agency must provide for the filing of uniform cost reports by each participating provider.

(e) *Audit requirements*. The Medicaid agency must provide for periodic audits of the financial and statistical records of participating providers.

(f) *Public notice*. The Medicaid agency must provide that it has complied with the public notice requirements in § 447.205 of this part when it is proposing significant changes to its methods or standards for setting payment rates for inpatient hospital or LTC facility services.

(g) *Rates paid*. The Medicaid agency must pay for inpatient hospital and long terms care services using rates determined in accordance with methods and standards specified in an approved State plan."

As adopted, 46 F.R. 47964 (Sept. 30, 1981), and corrected at 46 F.R. 54743 (Nov. 4, 1981), and amended at 47 F.R. 31518 (July 20, 1982), 48 F.R. 56046 (Dec. 19, 1983, effective Jan. 18, 1984), and at 52 F.R. 28141 (July 28, 1987).

11. In 1982, Virginia sought and received approval of an amendment to its State Plan to change the method by which hospitals were to be reimbursed for providing care to Medicaid patients. The effect of the amendment was to change Virginia from a retrospective reimbursement system to a prospective payment system. The amendment became the Medicaid Payment Program, Attachment 4.19-A of the State Plan. Thereafter, Attachment 4.19-A was amended to include the Appeal Regulations which amendment was approved by Marilyn Koch, Acting Regional Administrator, Health Care Financing Administration, Department of Health and Human Services, on March 3, 1986. (Attachment 4.19-A, as amended, is attached hereto as Exhibit 1.)

12. The Medicaid Payment Program went into effect on July 1, 1982 and at such time it did not comply with the requirements of the Medicaid Act despite the assurances and findings of the Commonwealth of Virginia and the approval of the Secretary of Health and Human Services. The assurances and findings provided by the Commonwealth were inaccurate, a fact which was known or reasonably should have been known to the predecessors of these defendants.

13. This failure is now known to the Defendants, as is the fact that the reimbursement rates established pursuant to the Amendment continue to fail to meet the requirements of the Medicaid Act and regulations promulgated thereunder. No action sufficient to correct its deficiencies has yet been taken.

14. The Virginia Medicaid Payment Program is the methodology by which a prospective payment rate will be set for hospitals providing care to Virginia Medicaid patients. In essence, Virginia's prospective payment system places hospitals into various "peer groups" based upon size and location. There are three rural peer groups and four urban peer groups based upon facility size. For each, a median cost of care for a Medicaid patient day was calculated using Medicaid cost reports filed by hospitals in calendar year 1981. In addition to these peer groupings, further adjustments were made for the urban peer groups based upon wage variations between metropolitan areas. The differentials for wages were based upon labor costs in the Standard Metropolitan Statistical Areas (hereinafter "SMSA") as developed by the federal government, Office of Management and Budget. Each peer group's median cost per day thus identified was then inflated using a consumer price index of general application, adjusted to exclude capital costs (hereinafter the "Va. CPI"), to arrive at a median cost of care as of July 1, 1982. These medians were then used to set quarterly ceilings on the rate of per diem reimbursement a hospital in each peer group could be paid.

15. Between July 1, 1982 and July 1, 1986, the Medicaid Payment Program calculated quarterly ceilings by applying the Va. CPI, as recalculated quarterly, to inflate

each peer group median to provide for inflation during the cost reporting period for which a rate was being set. The medians were not otherwise adjusted during any one fiscal year, but were inflated (not recomputed based upon actual costs) each subsequent July 1 based upon an updated Va. CPI. Up until July 1, 1986, quarterly peer group ceilings were calculated based on that year's median and the subsequent, quarterly Va. CPI.

16. Since July 1, 1986, the Medicaid Payment Program has employed a "medical care index (hereinafter the "MCI") as an inflation factor in setting quarterly peer group ceilings following the same adjustment approach it followed with the Va. CPI.

17. The per diem reimbursement rates established pursuant to Virginia's Medicaid Payment Program do not conform to the requirements of the Medicaid Act in that they have not reasonably nor adequately met the costs incurred by efficiently and economically operated hospitals in providing care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards to Medicaid patients.

18. In particular, a VHA study of all hospital cost reports covering cost report periods which began between October 1, 1982 through September 30, 1983 showed that approximately 95% of all hospitals in the Medicaid Payment Program in Virginia incurred costs necessary to provide care to Medicaid patients in excess of their individual peer group ceilings on reimbursement despite efficient and economical operation. At the outset of these cost reports, the Virginia Medicaid Payment Program projected that approximately 25% (*not* 50%) of them

would incur costs at or below the peer group ceilings established. Because these cost reports began just three months subsequent to the establishment of the July, 1982 medians, it is apparent that those medians were not true medians and that hospitals had no reasonable nor adequate opportunity to be reimbursed the necessary cost of providing care to Virginia Medicaid patients.

19. This early trend has continued to the present time and is worsening. A study done by the Department of Medical Assistance Services, which included actual information for costs reports ending in 1984 and made various projections for FYE 1985, showed that less than 5% of the hospitals providing care to Virginia's Medicaid patients were projected to incur costs at or below the ceiling in FYE 1985. Upon information and belief, the VHA alleges that virtually all hospitals will actually incur costs in excess of their Medicaid payments in FYE 1987.

20. Deficiencies in the prospective payment system established by the Virginia Medicaid Payment Program stem from the fact that from July 1, 1982 to July 1, 1986, hospital peer group payment ceilings were tied to a general inflation factor which not only fails to reflect accurately the level of inflation experienced in the hospital industry, but also fails to consider factors other than inflation which cause the cost of care per patient day to increase at efficiently and economically operated hospitals. Among the factors causing hospital per diem costs to rise, besides inflation and irrespective of whether a general or medical care specific index is utilized, are: changes in technology; changes in care practices by physicians and hospitals; availability of nurses; treatment of more

patients, both medical and surgical, in outpatient departments; decreases in the average length of stay per hospital admission, due to the earlier discharge of patients to home recuperation or nursing home care and the shift of inpatients to outpatient care; and the increasing intensity of the inpatient services rendered per patient day.

21. Because the actual costs incurred by hospitals in their cost reporting periods ending in 1981 were inflated to create the medians established July 1, 1982 through the utilization of an index which did not accurately reflect inflation in the hospital industry and did not measure other factors which would cause the per diem cost of care to rise, the peer group medians and ceilings established initially were materially understated, and this understatement was compounded with each annual update.

22. Because the Medicaid peer group relied upon these understated medians and inflated them until July 1, 1986 by using an identically calculated index to anticipate the upcoming year's inflation, this computation further compounds the understatement inherent in the medians.

23. The MCI takes into account the cost inflation in medical goods and services and is a more accurate and sensitive measure of hospital cost inflation than the Va. CPI; however, Defendants have misapplied their own published regulations in implementing MCI adjustments to peer group ceilings. The Defendants have retroactively applied only half of the MCI adjustment in setting each quarterly peer group ceiling since July 1, 1986.

24. Even if the medical CPI as employed by Defendants does adequately measure hospital cost inflation from year to year, the historical understatement inherent

in the peer group ceilings persists and will continue to persist absent recomputation.

25. Furthermore, because peer group ceilings are computed quarterly based upon the medians created each July 1, the understatement is even worse for hospitals beginning a cost report period other than on July 1 because inflation that has been incurred from July 1 through the day the cost report period begins is not reflected in the ceiling calculation. For instance, a hospital beginning its cost report on June 1, 1983 would use as its base the median for July 1, 1982. A hospital starting its cost report period on July 1, 1983 would use as its base the July 1, 1983 median, which was computed by taking the July 1, 1982 median and inflating it for the past twelve months of inflation. Thus, though there would only be one month's difference in the timing of the cost reports, the first hospital would be deprived of eleven months of inflation in this comparison.

26. Based upon comparisons of hospital costs per patient day, Virginia hospitals are low cost health care providers. Virginia, though ranking above average nationally in per capita income, ranks below average nationally in cost per patient day.

27. When comparing costs nationally, Virginia's cost have increased at a percentage consistent with the average increase in inpatient costs nationally. The other factors, affecting cost per patient day other than inflation, have also similarly tracked national experience.

28. As a result of the Medicaid Payment Program initiated in Virginia in 1982, hospitals participating in the Virginia Medicaid program have been under-reimbursed

by tens of millions of dollars. For instance, using the Department's analysis of cost reports ending in 1984, and re-computing medians based upon that data and adjusting them only through the use of an MCI inflation factor, hospitals would have been reimbursed over $13 million more for cost report periods ending in calendar year 1985 then under the current system. Such under-reimbursement has occurred in all years under the current Medicaid prospective payment system in Virginia and that disparity between cost and payment is increasing over time. For instance, a DMAS study of cost reports ending in 1984 showed the gap between payments and reimbursable costs to be approximately $29,000,000.

29. Approximately 50% of hospitals participating in the Virginia Medicaid Payment Program are required to do so because they have received funds under the Public Health Services Act, 42 U.S.C. 291, *et seq.*, commonly known as the Hill-Burton Act. These funds were provided for the construction of hospitals and were conditioned upon a hospital making community service assurances. Current regulations require all such hospitals to make arrangements, if eligible to do so, for reimbursement for services with federal governmental third party programs, such as Medicare and Medicaid, and to take any necessary steps to assure that admission to and services of the facility are available to beneficiaries of the governmental programs without discrimination or preference because they are beneficiaries of those programs. 42 CFR § 124.603(c). Because of this requirement, hospitals subject to these Hill-Burton requirements are required to participate in the Virginia Medicaid Program irrespective

of their success or failure in meeting the cost efficiency and economy mandates of the Medicaid Act.

30. The March 3, 1986 amendments to Attachment 4.19-A (hereinafter referred to as the "Appeal Regulations") create an appeal system in an attempt to comply with this Court's Order in the case of *Mary Washington v. Fisher*, Civil Action No. 83-0551-R, decided January 4, 1985. Initially, the proposed effective date was August 22, 1985. Defendant Sorrell has advised the VHA that the true effective date would be the date upon which the Secretary of Health and Human Services approved of the appeal regulations. Such approval was issued on March 3, 1986. Prior to that time, at least 81 hospitals had filed appeals seeking relief for current and past cost reporting periods on grounds substantially similar to those set forth in this Complaint. The Appeal Regulations at Section 1.C. make these grounds of relief non-appealable items and, thereby, preclude the relief being sought by those hospitals.

31. The Defendants have promulgated the Appeal Regulations as just that, an appeals process, not as a substitute for a defective prospective payment system. The Health Care Financing Administration has accepted the Appeal Regulations only as a "hospital appeals process", and not as a substitute for a defective prospective payment system.

32. The Appeal Regulations are inadequate as an appeal system and as a substitute prospective payment system in that:

(a) They are premised upon a false assumption that the current prospective payment system is consistent with federal law;

(b) They prohibit the appeal of this false assumption by making the establishment of peer groups, medians and ceilings and the use of a general CPI up until July 1, 1986 and the MCI thereafter non-appeal issues;

(c) They establish no concrete standard through which hospitals can reasonably anticipate what their rate will be set at before they begin a new cost report year;

(d) They do not produce an administratively final "prospective payment rate" for the cost report period in question until 55 days after that cost report period has ended, assuming that the entire administrative process is utilized without any extensions of the established timeframes;

(e) They establish a process for obtaining relief which is a subjective, case-by-case analysis through which hospitals must proceed individually;

(f) They establish individual hearing process and proof requirement for each appeal which are so time consuming and expensive that the opportunity for group appeals of common issues is inherently necessary to a meaningful appeal process;

(g) They combine the standards of economy and efficiency and access in determining the availability of relief to a hospital, such that a hospital that establishes that its costs are economically and efficiently incurred and are lower than the actual median costs incurred by other

hospitals in its peer group, can nevertheless be denied relief to which legally entitled under the access standard; and

(h) They are otherwise inconsistent with the Medicaid Act and do not provide a meaningful appeals system, especially in light of the underlying deficiencies in prospective payment under the Virginia Medicaid Payment Program.

33. The injury to Virginia hospitals described above is immediate, irreparable, and without an adequate remedy at law.

III. *CAUSES OF ACTION*

COUNT I

34. Plaintiff repeats and realleges the allegations set forth in paragraphs 1-33 of this Complaint.

35. Count I of this Complaint seeks a declaratory judgment pursuant to 28 U.S.C. §§ 2201, *et seq.* and 42 U.S.C. § 1983 that in enacting, enforcing and implementing Attachment 4.19-A to the Virginia State Plan under Title XIX of the Social Security Act, the Defendants, jointly and severally, have violated the provisions of the Medicaid Act, Title XIX of the Social Security Act, 42 U.S.C. § 1396, *et seq.*, and regulations promulgated thereunder, and their actions are therefore unconstitutional under the Supremacy Clause of the United States Constitution, Article VI, Section 2 thereof based upon the facts, circumstances and reasons set forth above.

COUNT II

36. Plaintiff repeats and realleges the allegations set forth in paragraphs 1-33 of this Complaint.

37. Count II of this Complaint seeks a declaratory judgment pursuant to 28 U.S.C. §§ 2201, *et seq.* and 42 U.S.C. § 1983 that Attachment 4.19-A of the Virginia State Plan under Title XIX of the Social Security Act, as amended, is unconstitutional under the Due Process Clause of the Fourteenth Amendment of the United States Constitution based upon the facts, circumstances and reasons set forth above.

COUNT III

38. Plaintiff repeats and realleges the allegations set forth in paragraphs 1-33 of this Complaint.

39. Count III of this Complaint seeks preliminary and permanent injunctive relief pursuant to Rule 65 of the Federal Rules of Civil Procedure and 42 U.S.C. § 1983 enjoining the enforcement of Attachment 4.19-A of the Virginia State Plan under Title XIX of the Social Security Act, as amended, in that the Plaintiff's member hospitals will be irreparably harmed by the continued operation of Attachment 4.19-A by being subject to an unapproved payment system and being denied the payment to which they are entitled under the Medicaid Act, 42 U.S.C. § 1396 *et seq.*, based upon the facts, circumstances and reasons set forth above.

WHEREFORE, the Plaintiff requests that the Court enter an Order herein granting to the Plaintiff the following relief:

1. A declaration that Attachment 4.19-A is unconstitutional under the Supremacy Clause and the Due Process Clause both as to the "Method and Standards for Establishing Payment Rates – In-Patient Care and the

"Final Regulations for Hospital Appeals of Reimbursement Rates".

2. A preliminary and a permanent injunction against the operation of Attachment 4.19-A of the Virginia State Plan under Title XIX of the Social Security Act, as amended, in particular the "Method and Standards of Establish Payment Rates – In-Patient Care" and the "Final Regulations for Hospital Appeals of Reimbursement Rates", such injunction to include:

(a) An Order that the Defendants promulgate and have approved by the Secretary of Health and Human Services a hospital payment system under the Virginia State Plan under Title XIX of the Social Security Act which complies with 42 U.S.C. § 1396 *et seq.*, and federal regulations adopted thereunder;

(b) An Order that pending such promulgation and approval the defendants in the interim are to reimburse hospitals participating in the Virginia State Plan at a level commensurate with payment under Title XVIII of the Social Security Act, as amended, commonly known as the Medicare Act; and

(c) An Order that the Defendants promulgate an appeals system which will enable hospitals participating in the Virginia State Plan under Title XIX of the Social Security Act to seek reimbursement for their cost reports still open to appeal by allowing them to directly attack the establishment of peer groups, medians, and ceilings and the use of a particular ceiling inflation index individually and by group appeal and which will otherwise provide a meaningful appeals system to hospitals.

Respectfully submitted,

THE VIRGINIA HOSPITAL ASSOCIATION
By: /s/ Martin A. Donlan, Jr.
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CERTIFICATE OF SERVICE

I hereby certify that on this first day of February, 1988 that a true and accurate copy of the foregoing Amended Complaint was mailed, postage prepaid, to Roger L. Chaffe, Senior Assistant Attorney General, Commonwealth of Virginia, 101 North Eighth Street, Richmond, Virginia 23219.

/s/ Peter M. Mellette

State of Virginia
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – IN-PATIENT CARE

The state agency will pay the reasonable cost of in-patient hospital services provided under the plan. In reimbursing hospitals for the cost of in-patient hospital services provided to recipients of medical assistance.

I. For each hospital also participating in the Health Insurance for the Aged program under Title XVIII of the Social Security Act, the state agency will apply the same standards, cost reporting period, cost reimbursement principles, and method of cost apportionment currently used in computing reimbursement to such a hospital under Title XVIII of the Act, except that the in-patient routine services costs for medical assistance recipients will be determined subsequent to the application of the Title XVIII method of apportionment, and the calculation will exclude the applicable Title XVIII in-patient routine service charges or patient days as well as Title XVIII in-patient routine service cost.

II. For each hospital not participating in the program under Title XVIII of the Act, the state agency will apply the standards and principles described in 42 CFR 447.250 and either (a) one of the available alternative cost apportionment methods in 42 CFR 447.250, or (b) the "Gross RCCAC method" of cost apportionment applied as follows: For a reporting period, the total allowable hospital in-patient charges; the resulting percentage is applied to the bill of each in-patient under the Medical Assistance Program.

III. For either participating or non/participating facilities, the Medical Assistance Program will pay no more in the aggregate for inpatient hospital services than the amount it is estimated would be paid for the services under the Medicare principles of reimbursement, as set forth in 42 CFR 447.253(b)(2), and/or lessor of reasonable cost or customary charges in 42 CFR 447.250.

IV. The state agency will apply the standards and principles as described in the state's reimbursement plan approved by the Secretary on a demonstration or experimental basis for the payment of reasonable costs by methods other than those described in paragraphs a and b above.

TN No._____ Approval Date FEB 23 1988
Effective Date JUL 31 1987

Supercedes
TN No.________

V. The reimbursement system for hospitals includes the following components:

(1) Hospitals should be grouped by classes according to number of beds and urban versus rural. (Three groupings for rural – less than 100 beds, 101 to 170 beds, and over 171 beds; four groupings for urban – less than 100, 100 to 400 to 401 to 600, and over 601 beds.) Groupings are similar to those used by the Health Care Financing Administration (HCFA) in determining routine cost limitations.

(2) Prospective reimbursement ceilings on allowable operating costs should be established as of July 1, 1982, for each grouping. Hospitals with a fiscal year end after June 30, 1982 shall be subject to the new reimbursement ceilings.

The calculation of the initial group ceilings as of July 1, 1982, should be based on available, allowable cost data for all hospitals in calendar year 1981. Individual hospital operating costs should be advanced by a reimbursement escalator from the hospital's year end to July 1, 1982. After this advancement, the operating costs

should be standardized using SMSA wage indices, and median should be determined for each group. These medians should be re-adjusted by the wage index to set an actual cost ceiling for each SMSA. Therefore, each hospital grouping should have a series of ceilings representing one of each SMSA area. The wage index should be based on those used by HCFA in computing its Market Basket Index for routine cost limitations.

Effective July 1, 1986, providers subject to the prospective payment system of reimbursement will have their prospective operating cost rate and prospective operating cost ceiling computed using a new methodology. This new method will use an allowance for inflation based on the percent of change in the quarterly average of the Medical Care Index of the Chase Econometrics – Standard Forecast determined in the quarter in which the provider's new fiscal year begins.

The prospective operating cost rate will be based on the provider's allowable cost from the most recent filed cost report, plus the inflation percentage add-on.

The prospective operating cost ceiling will be determined by using the base that was in effect for the provider's fiscal year that began between July 1, 1985, and June 1, 1986. The medical care index percent of change for the quarter in which the provider's new fiscal year began will be added to this base to determine the new operating cost ceiling. This new ceiling is to be effective for all providers on July 1, 1986. For subsequent cost reporting periods beginning on or after July 1, 1986, the last prospective operating rate ceiling determined under this new methodology will become the

base for computing the next prospective year ceiling.

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The new method will still require comparison of the prospective operating cost rate to the prospective operating ceiling. The provider is allowed the lower of the two amounts subject to the lower of cost or charges principles.

(3) Subsequent to June 30, 1982, the group ceilings should not be recalculated on allowable costs, but should be updated by the escalator.

(4) Prospective rates for each hospital should be based upon the hospital's allowable costs plus the escalator, or the appropriate ceilings, or charges; whichever is lower. Except to eliminate costs that are found to be unallowable, no retrospective adjustment should be made to prospective rates.

Depreciation, capital interest, and education costs approved pursuant to HIM-15 (Sec. 400), should be considered as pass throughs and not part of the calculation.

(5) Hospitals which have a disproportionately higher level of Medicaid patients and which exceed the ceiling should be allowed a higher ceiling based on the individual hospital's Medicaid utilization. This should be measured by the percent of Medicaid patient days to total hospital patient days. Each hospital with a Medicaid utilization of over 8% should receive an adjustment to its ceiling. The adjustment should be set at a percent added to the ceiling for each percent of utilization up to 30%.

(6) There will be special consideration for exception to the median operating cost limits in those instances where extensive neonatal care is provided.

(7) An incentive plan should be established whereby a hospital will be paid on a sliding scale, percentage for percentage, up to 25% of the difference between allowable operating costs and the appropriate per diem group ceiling when the operating costs are below the ceilings. The incentive should be calculated based on the annual cost report.

The table below presents three examples under the new plan:

Group Ceiling	Hospital's Allowable Cost Per Day	Difference $	Difference % of Ceiling	Sliding Scale Incentive $	Sliding Scale Incentive % of Difference
$230	$230	-0-	-0-	-0-	-0-
230	207	23.00	10%	2.30	10%
230	172	57.50	25%	14.38	25%
230	143	76.00	33%	19.00	25%

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VI. In accordance with the requirements of Section 1902(a)(13)(A) of the Social Security Act and in accordance with the regulations at 42 CFR 447.250 through 447.272, the Virginia Medical Assistance Program will continue using the Medicare retrospective cost system guidelines to determine allowable costs for Virginia's prospective payment system. Virginia adheres to the Medicare principles in effect prior to October 1, 1983.

VII. Reevaluation of Assets

A. Effective October 1, 1984, the valuation of an asset of a hospital or long – term care facility which has undergone a change of ownership on or after July 18, 1984, shall be the lesser of the allowable acquisition cost to the owner of record as of July 18, 1984, or the acquisition cost to the new owner.

B. In the case of an asset not in existence as of July 18, 1984, the valuation of an asset of a hospital or long-term care facility shall be the lesser of the first owner of record, or the acquisition cost to the new owner.

C. In establishing an appropriate allowance for depreciation, interest on capital indebtedness, and return on equity (if applicable prior to July 1, 1986) the base to be used for such computations shall be limited to A or B above.

D. Costs (including legal fees, accounting and administrative costs, travel costs, and feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) shall be reimbursable only to the extent that they have not been previously reimbursed by Medicaid.

E. The recapture of depreciation up to the full value of the asset is required.

F. Rental charges in sale and leaseback agreements shall be restricted to the depreciation, mortgage interest and (if applicable prior to July 1, 1986) return on equity based on the cost of ownership as determined in accordance with A and B above.

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Effective Date JUL 31 1987

Supercedes
TN No.________

VIII. Refund of Overpayments – Effective July 1, 1986

A. *Lump Sum Payment*. When the provider files a cost report indicating that an overpayment has occurred, full refund is to be remitted with the cost report, or, in cases where DMAS discovers an overpayment during desk review, field audit, or final settlement, DMAS will immediately send the first demand letter requesting a lump sum refund. Recovery will be undertaken even though the provider disputes in whole or in part DMAS's determination of the overpayment.

B. *Payment Schedule*. If the provider cannot refund the total amount of the overpayment within thirty (30) days after receiving the letter, the provider should immediately request an extended repayment schedule. DMAS may establish a repayment schedule of up to twelve (12) months to recover all or part of an overpayment.

It must offset any money owed to the provider prior to establishing a repayment plan. When a repayment schedule is used to recover only part of an overpayment, the remaining amount should be recovered by the reduction of interim payments to the provider or by lump sum payments.

C. *Extension Request Documentation*. The provider must document its need for extended (beyond thirty (30) days repayment and resubmit a written proposal scheduling the dates and amounts of repayments. The Program will send the provider written notification of the approved repayment schedule, which will be in effect from the date the provider submits the proposal. If an audit later uncovers an additional overpayment, the provider must submit further documentation if it wishes to

request an extended repayment schedule for the additional amount.

D. *Interest Charge on Extended Repayment*. Interest will be charged to the provider at the rate specified in Section 32.1-313 of the *Code of Virginia* (1950) as amended, on the unpaid balance of the approved repayment schedule. Interest will accrue from the date the overpayment is determined. Interest will not be charged or accrued during the period of the Program's administrative review. Interest will be charged on any unpaid balance from the date of the Director's final administrative determination.

In any case in which any initial determination of overpayment has been reversed in a subsequent judicial proceeding, the provider shall be reimbursed that portion of the payment to which he is entitled, plus any applicable interest paid.

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Supercedes TN ________ Effective date July 11

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IX. Effective October 1, 1986, hospitals that have obtained Medicare certification as inpatient rehabilitation hospitals or rehabilitation units in acute care hospitals, which are exempted from the Medicare Prospective Payment System (DRG), shall be reimbursed in accordance with the current Medicaid Prospective Payment System as described in the preceding sections I, II, III, IV, V (excluding (6)), VI, VII, VIII. Additionally, rehabilitation hospitals and rehabilitation units of acute care hospitals which are exempt from the Medicare Prospective Payment System will be required to maintain separate cost accounting records, and to file separate cost reports

annually utilizing the applicable Medicare cost reporting forms, (HCFA 2552 series), and the Medicaid forms (MAP-783 series).

A new facility shall have an interim rate determined using a pro forma cost report or detailed budget prepared by the provider and accepted by DMAS, which represents its anticipated allowable cost for the first cost reporting period of participation. For the first cost reporting period, the provider will be held to the lesser of its actual operating costs or its peer group ceiling. Subsequent rates will be determined in accordance with the current Medicaid Prospective Payment System as noted in the preceding paragraph of IX.

X. Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

TN No._____ Approval Date FEB 23 1988
Effective Date JUL 31 1987

Supercedes
TN No.________

FINAL REGULATIONS FOR HOSPITAL APPEALS OF REIMBURSEMENT RATES

§ 1. RIGHT TO APPEAL AND INITIAL AGENCY DECISION

A. *Right to Appeal*: Any hospital seeking to appeal its prospective payment rate for operating costs related to inpatient care or other allowable costs shall submit a written request to the Department of Medical Assistance Service within 30 days of the date of the letter notifying the hospital of its prospective rate unless permitted to do otherwise under § 5E. The written request for appeal

must contain the information specified in § 1B. The Department shall respond to the hospital's request for additional reimbursement within 30 days or after receipt of any additional documentation requested by the Department, whichever is later. Such agency response shall be considered the initial agency determination.

B. *Required Information*: Any request to appeal the prospective payment rate must specify: (i) the nature of the adjustment sought; (ii) the amount of the adjustment sought; and (iii) current and prospective cost containment efforts, if appropriate.

C. *Non-Appealable Issues*: The following issues will not be subject to appeal: (i) the organization of participating hospitals into peer groups according to location and bed size and the use of bed size and the urban/rural distinction as a generally adequate proxy for case mix and wage variations between hospitals in determining reimbursement for inpatient care; (ii) the use of Medicaid and applicable Medicare Principles of Reimbursement to determine reimbursement of costs other than operating costs relating to the provision of inpatient care; (iii) the calculation of the initial group ceilings on allowable operating costs for inpatient care as of July 1, 1982; (iv) the use of the Bureau of Labor Statistics Consumer Price Index (CPI) (excluding housing and interest components) as the prospective escalator; and (v) durational limitations set forth in the State Plan (the "twenty-one day rule").

D. The rate which may be appealed shall include costs which are for a single cost reporting period only.

E. The hospital shall bear the burden of proof throughout the administrative process.

§ 2. ADMINISTRATIVE APPEAL OF ADVERSE INITIAL AGENCY DETERMINATION

A. *General*: The administrative appeal of *an* adverse initial agency determination shall be made in accordance with the Virginia Administrative Process Act, §§ 9-6.14:11 through 9-6.14:14 of the Code of Virginia, as set forth below.

B. *The Informal Proceeding*:

1. The hospital shall submit a written request to appeal an adverse initial agency determination in accordance with § 9-6.14:11 of the Code of Virginia within 15 days of the date of the letter transmitting the initial agency determination.

2. The request for an informal conference in accordance with § 9-6.14:11 of the Code of Virginia shall include the following information:

a. the adverse agency action appealed from;

b. a detailed description of the factual data, argument or information the hospital will rely on to challenge the adverse agency decision.

3. The agency shall afford the hospital an opportunity for *an* informal conference in accordance with § 9-6.14:11 of the Code of Virginia within 45 days of the request.

4. The Director of the Division of Provider Reimbursement of the Department of Medical Assistance

Services, or his designee, shall preside over the informal conference. As hearing officer, the Director, or his designee, may request such additional documentation or information from the hospital or agency staff as may be necessary in order to render an opinion.

5. After the informal conference, the Director of the Division of Provider Reimbursement, having considered the criteria for relief set forth in §§ 4 and 5, shall take any of the following actions:

a. notify the provider that its request for relief is denied setting forth the reasons for such denial; or

b. notify the provider that its appeal has merit and advise it of the agency action which will be taken; or

c. notify the provider that its request for relief will be granted in part and denied in part, setting forth the reasons for the denial in part and the agency action which will be taken to grant relief in part.

6. The decision of the informal hearing officer shall be rendered within 30 days of the conclusion of the informal conference.

§ 3. THE FORMAL ADMINISTRATIVE HEARING: PROCEDURES

A. The hospital shall submit its written request for a formal administrative hearing under § 9-6.14:12 of the Code of Virginia within 15 days of the date of the letter transmitting the adverse informal agency decision.

B. At least 21 days prior to the date scheduled for the formal hearing, the hospital shall provide the agency with:

1. Identification of the adverse agency action appealed from, and

2. A summary of the factual data, argument and proof the provider will rely on in connection with its case.

C. The agency shall afford the provider an opportunity for a formal administrative hearing within 45 days of the receipt of the request.

D. The Director of the Department of Medical Assistance Services, or his designee, shall preside over the hearing. Where a designee presides, he shall make recommended findings and a recommended decision to the Director. In such instance, the provider shall have an opportunity to file exceptions to the proposed findings and conclusions. In no case shall the designee presiding over the formal administrative hearing be the same individual who presided over the informal appeal.

E. The Director of the Department of Medical Assistance Services shall make the final administrative decision in each case.

F. The decision of the agency shall be rendered within 60 days of the conclusion of the administrative hearing.

§ 4. THE FORMAL ADMINISTRATIVE HEARING: NECESSARY DEMONSTRATION OF PROOF

A. The hospital shall bear the burden of proof in seeking relief from its prospective payment rate.

B. A hospital seeking additional reimbursement for operating costs relating to the provision of inpatient care

shall demonstrate that its operating costs exceed the limitation on operating costs established for its peer group and set forth the reasons for such excess.

C. In determining whether to award additional reimbursement to a hospital for operating costs relating to the provision of inpatient care, the Director of the Department of Medical Assistance Services shall consider the following:

1. Whether the hospital has demonstrated that its operating costs are generated by factors generally not shared by other hospitals in its peer group. Such factors may include, but are not limited to, the addition of new and necessary services, changes in case mix, extraordinary circumstances beyond the control of the hospital, and improvements imposed by licensing or accrediting standards.

2. Whether the hospital has taken every reasonable action to contain costs on a hospital-wide basis.

a. In making such a determination, the Director or his designee may require that an appellant hospital provide quantitative data, which may be compared to similar data from other hospitals within that hospital's peer group or from other hospitals deemed by the Director to be comparable. In making such comparisons, the Director may develop operating or financial ratios which are indicators of performance quality in particular areas of hospital operation. A finding that the data or ratios or both of the appellant hospital fall within a range exhibited by the majority of comparable hospitals, may be construed by the Director to be

evidence that the hospital has taken every reasonable action to contain costs in that particular area. Where applicable, the Director may require the hospital to submit to the agency the data it has developed for the Virginia Health Services Cost Review Commission. The Director may use other data, standards or operating screens acceptable to him. The appellant hospital shall be afforded an opportunity to rebut ratios, standards or comparisons utilized by the Director or his designee in accordance with this section.

b. Factors to be considered in determining effective cost containment may include the following:

- Average daily occupancy
- Average hourly wage
- FTE's per adjusted occupied bed
- Nursing salaries per adjusted patient day
- Average length of stay
- Average cost per surgical case
- Cost (salary/non-salary) per ancillary procedure
- Average cost (food/non-food) per meal served
- Average cost per pound of laundry
- Cost (salary/non-salary) per pharmacy prescription
- Housekeeping cost per square foot
- Maintenance cost per square foot
- Medical records cost per admission
- Current Ratio (current assets to current liabilities)

- Age of receivables
- Bad debt percentage
- Inventory turnover
- Measures of case mix

c. In addition, the Director may consider the presence or absence of the following systems and procedures in determining effective cost containment in the hospital's operation.

- Flexible budgeting system
- Case mix management systems
- Cost accounting systems
- Materials management system
- Participation in group purchasing arrangements
- Productivity management systems
- Cash management programs and procedures
- Strategic planning and marketing
- Medical records systems
- Utilization/Peer review systems

d. Nothing in this provision shall be construed to require a hospital to demonstrate every factor set forth above or to preclude a hospital from demonstrating effective cost containment by using other factors.

The Director or his designee may require that an onsite operational review of the hospital be conducted by the Department or its designee.

3. Whether the hospital has demonstrated that the Medicaid prospective payment rate it receives to

cover operating costs related to inpatient care is insufficient to provide care and service that conforms to applicable state and federal laws, regulations and quality and safety standards.[1]

D. In no event shall the Director of the Department of Medical Assistance Services award additional reimbursement to a hospital for operating costs relating to the provision of inpatient care, unless the hospital demonstrates to the satisfaction of the Director that the Medicaid rate it receives under the Medicaid prospective payment system is insufficient to ensure Medicaid recipients reasonable access to sufficient inpatient hospital services of adequate quality.[2] In making such demonstration, the hospital shall show that:

1. The current Medicaid prospective payment rate jeopardizes the long-term financial viability of the hospital. Financial jeopardy is presumed to exist if, by providing care to Medicaid recipients at the current Medicaid rate, the hospital can demonstrate that it is, in the aggregate, incurring a marginal loss[3].

For purposes of this section marginal loss is the amount by which total variable costs for each patient day exceed the Medicaid payment rate. In calculating marginal loss, the hospital shall compute variable costs at 60% of total inpatient operating costs and fixed costs at 40% of total inpatient operating costs; however, the Director may accept a different ratio of fixed and variable operating costs if a hospital is able to demonstrate that a different ratio is appropriate for its particular institution.

Financial jeopardy may also exist if the hospital is incurring a marginal gain but can demonstrate that it has

unique and compelling Medicaid costs, which if unreimbursed by Medicaid, would clearly jeopardize the hospital's long-term financial viability and,

2. The population served by the hospital seeking additional financial relief has no reasonable access to other inpatient hospitals. Reasonable access exists if most individuals served by the hospital seeking financial relief can receive inpatient hospital care within a 30 minute travel time at a total per diem rate which is less to Department of Medical Assistance Services than the costs which would be incurred by DMAS per patient day were the appellant hospital granted relief.[4]

E. In determining whether to award additional reimbursement to a hospital for reimbursable costs which are other than operating costs related to the provision of inpatient care, the Director shall consider Medicaid and applicable Medicare rules of reimbursement.

§ 5. AVAILABLE RELIEF

A. Any relief granted under §§ 1-4 shall be for one cost reporting period only.

B. Relief for hospitals seeking additional reimbursement for operating costs incurred in the provision of inpatient care shall not exceed the difference between:

1. The cost per allowable Medicaid day arising specifically as a result of circumstances identified in accordance with § 4 (excluding plant and education costs and return on equity capital) *and*

2. The prospective operating cost per diem, identified in the Medicaid Cost Report and calculated by DMAS.[5]

C. Relief for hospitals seeking additional reimbursement for (i) costs considered as "pass-throughs" under the prospective payment system or (ii) costs incurred in providing care to a disproportionate number of Medicaid recipients or (iii) costs incurred in providing extensive neonatal care shall not exceed the difference between the payment made and the actual allowable cost incurred.

D. Any relief awarded under §§ 1-4 shall be effective from the first day of the cost period for which the challenged rate was set. Cost periods for which relief will be afforded are those which begin on or after January 4, 1985. In no case shall this limitation apply to a hospital which noted an appeal of its prospective payment rate for a cost period prior to January 4, 1985.

E. All hospitals for which a cost period began on or after January 4, 1985, but prior to the effective date of these regulations, shall be afforded an opportunity to be heard in accordance with these regulations if the request for appeal set forth in § 1A is filed within ninety days of the effective date of these regulations.

§ 6. CATASTROPHIC OCCURRENCE

A. Nothing in §§ 1 through 5 shall be construed to prevent a hospital from seeking additional reimbursement for allowable costs incurred as a consequence of a natural or other catastrophe. Such reimbursement will be paid for the cost period in which such costs were

incurred and for costs periods beginning on or after July 1, 1982.

B. In order to receive relief under this section, a hospital shall demonstrate that the catastrophe met the following criteria:

1. One time occurrence;
2. Less than twelve months duration;
3. Could not have been reasonably predicted;
4. Not of an insurable nature;
5. Not covered by federal or state disaster relief;
6. Not a result of malpractice or negligence.

C. Any relief sought under this section must be calculable and auditable.

D. The agency shall pay any relief afforded under this section in a lump sum.

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[1] See 42 U.S.C. § 1396 (a)(13)(A). This provision reflects the Commonwealth's concern that she reimburse only those excess operating costs which are incurred because they are needed to provide adequate care. The Commonwealth recognizes that hospitals may choose to provide more than "just adequate" care and, as a consequence, incur higher costs. In this regard, the Commonwealth notes that "Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs. Instead, the benefit provided through Medicaid is a particular package of health care services . . . that package of services has the general aim of assuring that individuals will receive necessary medical care, but the benefit provided remains the individual services offered – not 'adequate health care'." *Alexander*

v. *Choate*, ___ U.S. ___ decided January 9, 1985, 53 U.S.L.W. 4072, 4075.

[2] In *Mary Washington Hospital* v. *Fisher*, the court ruled that the Medicaid rate "must be adequate to ensure reasonable access". *Mary Washington Hospital* v. *Fisher*, at p. 18. The need to demonstrate that the Medicaid rate is inadequate to ensure recipients reasonable access derives directly from federal law and regulation. In its response to comments on the NPRM published September 30, 1981, HCFA points out Congressional intent regarding the access issue:

> The report on H.R. 3982 states the expectation that payment levels for inpatient services will be adequate to assure that a sufficient number of facilities providing a sufficient level of services actively participate in the Medicaid program to enable all Medicaid beneficiaries to obtain quality inpatient services. This report further states that payments should be set at a level that ensures the active treatment of Medicaid patients in a majority of the hospitals in the state.

46 Fed. Reg. 47970.

[3] The Commonwealth believes that Congressional intent is threatened in situations in which a hospital is incrementally harmed for each additional day a Medicaid patient is treated – and therefore has good cause to consider withdrawal from the program – and where no alternative is readily available to the patient, should withdrawal occur. Otherwise, although the rate being paid a hospital may be less than that paid by other payors – indeed, less than *average* cost per day for all patients – it nonetheless equals or exceeds the variable cost per day, and therefore benefits the hospital by offsetting some amount of fixed costs, which it would incur even if the bed occupied by the Medicaid patient were left empty.

It should be emphasized that application of this marginal loss or "incremental harm" concept is a device to assess the potential harm to a hospital continuing to treat Medicaid recipients, and not a mechanism for determining the additional payment due to a successful appellant. As discussed below,

once a threat to access has been demonstrated, the Commonwealth may participate in the full average costs associated with the circumstances underlying the appeal.

[4] With regard to the thirty minute travel standard, this requirement is consistent with general health planning criteria regarding acceptable travel time for hospital care.

[5] The Commonwealth recognizes that in cases where circumstances warrant relief beyond the existing payment rate, she may share in the cost associated with those circumstances. This is consistent with the existing policy, whereby payment is made on an average per diem basis. The Commonwealth will not reimburse more than her share of fixed costs. Any relief to an appellant hospital will be computed using patient days adjusted for the level of occupancy during the period under appeal. In no case will any additional payments made under this rule reflect lengths of stay which exceed the twenty-one day limit currently in effect.

AFFIDAVIT

I, J. John McMahon state as follows:

1. I am currently employed as Vice President/Finance of the Virginia Hospital Association, (VHA), a position I have held since October 17, 1986.

2. In my position, I have become familiar with figures, provided to VHA by the State Department of Medicaid Assistance Services (DMAS), reflecting Medicaid and Medicare costs and reimbursement for member hospitals of the Virginia Hospital Association.

3. It is standard practice for VHA member hospitals to file Medicaid cost reports three months after the end of each Hospital's fiscal year. These reports are not audited for some time thereafter. Because of this time lag in reporting and auditing figures, 1986 is the last year for which information is currently available.

4. In 1982, the difference between Medicaid costs, determined to be reasonable and necessary after state and Federal audits, and Medicaid reimbursement of such costs was $2,178,157. This shortfall increased to $15,810,254 in 1983, to $19,277,523 in 1984, to $28,477,491 in 1985 and to $29,233,350 in 1986.

5. In 1983, on average, the reimbursement shortfall per Medicaid patient day was $46.91. In 1986, the average reimbursement shortfall per Medicaid patient day was $92.30.

6. In my position, I have also become familiar with the VHA's hospital membership, the VHA membership dues assessment method, and the VHA's effort in collecting those dues.

7. VHA member dues are assessed and payable in a lump sum on or about January 1 of each year.

8. Since 1982, I am aware of increasing instances in which hospital members have been unable to pay their annual assessments in full and on time. Those hospitals claimed financial hardship as a result of an inability to cover their patient care costs and provide needed services within the reimbursement levels of third party payors, including Medicaid.

9. Since 1982, I am also aware of hospitals who have allowed their VHA membership to lapse due to financial hardship, again resulting from an inability to cover their patient care costs and provide needed services within the reimbursement levels of third party payors, including Medicaid.

Pursuant to 28 U.S.C. § 1746, I hereby state under penalty of perjury that the foregoing is true and correct.

/s/ J. John McMahon
J. JOHN McMAHON

STATE OF VIRGINIA

CITY/COUNTY OF Henrico, to-wit:

Subscribed and sworn to before me this 24th day of February, 1988.

My commission expires: 4/16/91

/s/ Susan H. Pangelman
Notary Public

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF VIRGINIA Richmond Division

THE VIRGINIA HOSPITAL ASSOCIATION, Plaintiff,	)	CIVIL ACTION NO. 86-1066-R
v.	)	
GERALD L. BALILES, *et al.*, Defendants.	)	

AFFIDAVIT

COMMONWEALTH OF VIRGINIA
to-wit,

I, Joseph Becht, being duly sworn do affirm and state:

1. I am presently Senior Manager, Health Care Consulting, with the firm of Ernst and Whinney.

2. I am familiar with the prospective payment system used by the Commonwealth of Virginia to reimburse hospitals participating in the State Medical Assistance Program and with recent proposed changes to this system.

3. Attached hereto and incorporated herein by this reference is a true and accurate copy of my curriculum vitae.

4. In the course of preparing this affidavit, I have reviewed the pleadings to date in this case, including the affidavits of Messers Nelson Ford and Ray T. Sorrell.

5. The facts set forth herein are based upon my personal knowledge and the records of the Department of Medical Assistance Services. ("DMAS") The opinions

expressed are based upon my knowledge and experience in health care financial management and upon information regularly relied upon by health care financial managers in forming opinions and advising health care providers with respect to third party reimbursement and other financial management issues.

6. Scientific and technological advancements are known to cause hospital operating costs both to rise and fall. A recent analysis performed by the Prospective Payment Assessment Commission ("PRO PAC"), a federal commission created to annually advise the Secretary of Health and Human Services on an appropriate update factor for Medicare prospective payments to hospitals and on needed changes in the diagnosis-related groups (DRGs) on which Medicare reimbursement is based, similarly concluded that such advances cause operating cost to rise and fall. *See* CCH Medicare and Medicaid Guide, Extra Edition, No. 520, April 21, 1987. PRO PAC's report concluded that scientific and technological advances, however, caused a net increase in hospital costs. It is my opinion that PRO PAC's determination is valid and that the net effect of future technological and scientific advances has caused and is likely to continue to cause hospital operating costs to rise independent of inflation.

7. In addition to the above, it is important to note that the PRO PAC assessment of the impact of scientific and technological advances is based upon costs per hospital admission, not costs per hospital day. Because, as noted below, the average length of stay per admission has been decreasing, there is good reason to expect that those advances which reduce cost per case will not necessarily reduce the cost per day for the remaining days in an

admission. In fact, it is more probable that they will increase the per day cost for such days because at a minimum there are fewer days over which to spread fixed operating costs.

8. The Virginia Medicaid Program, a per diem reimbursement system, in fact provides no incentive to reduce a patient's length of stay because such a reduction directly reduces the amount of reimbursement received for a patient's care. On the other hand, a reduction in average length of stay provides the quickest and greatest savings to such a payor. For instance, based upon the statistical information published by DMAS, "Reimbursement Methodology Study, Phase III Report, Input and Output Hospital Reimbursement Alternatives, March 1987," total Medicaid days dropped from 375,273 to 301,154, but Medicaid discharges only dropped from 60,399 to 57,404. The result is a decline in average Medicaid length of stays from 6.22 days in 1982 to 5.25 days in 1986. For cost report periods ending in 1986, Medicaid reimbursable days were reimbursed at an average rate of $346.23 per day, based upon a DMAS study referenced as "DMAS Model Name: HTEMPLAT-Revised Data-Updated 9/11/87.") ("Revised Data") Given the 57,404 discharges in 1986, if Medicaid length of stays had not declined by approximately one day since 1982, there would have been 57,404 additional days charged to the Medicaid Program. The total savings realized by the Medicaid Program amounted to approximately $19.8 million based upon the 1986 average reimbursement per patient day.

9. As noted in Mr. Ford's affidavit, there are variables such as changes in length of stay, productivity increases, changes in medical practices, and scientific and

technological advances which impact upon hospital costs. In other words, there are variables in addition to inflation which will cause hospital costs per day to rise or fall. Admittedly, the Medicaid program does not measure these variables because it uses a simple inflator as an update factor for Virginia's prospective payment system. Such factors can be measured. The failure to measure these variables indicates that the defendants have not developed the necessary information to assure the Secretary annually that their rates are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities and to assure Medicaid beneficiaries reasonable access to inpatient services of adequate quality. 42 C.F.R. § 447.253(a) (b). If it is true, as Mr. Ford suggests, that the measurement of such variables is impossible, then DMAS cannot give the necessary assurances required of state medical assistance programs.

10. The principle theme of the Virginia Medicaid Program is set forth in the affidavit of Mr. Ford, paragraph 10 as follows:

> Under prospective payment principles, there is no direct relationship between payment rates and those costs needed to function in an efficient and economic manner.

This statement is absolutely true for the Virginia Medicaid prospective payment system. However, if a Medicaid program is to set rates which are "reasonable and adequate to meet the costs which must be incurred by the efficiently and economically operated facilities" there must be a "direct relationship between payment rates" and "needed costs". It is this lack of a direct relationship, which has largely been created by the use of an update

factor which measures only one of the applicable variables, i.e., inflation, which has caused the dramatic disparity between hospital reimbursement and Medicaid allowable costs.

11. While prospective rates are set in advance, they cannot be set so low that hospital are not reimbursed their "needed costs" of providing care; otherwise, any appeal system becomes an *ad hoc* rate system because many hospitals will require and should be entitled to relief from such rates.

12. Prospective payments systems should include an "appropriate escalator" which considers the effects of inflation along with changes in length of stay, productivity increases, changes in medical practices, scientific and technological advancements, and other factors. The Health Care Financing Administration uses an "update factors" which includes not only an "inflator" but also considers other variables.

13. The variables which should be considered when setting update factors, however, can impact on per diem and per case systems differently. For example, assume that all variables remain constant except average length of stay. In a hypothetical surgical admission, next assume that on the first day of hospitalization the patient has surgery, the second day he receives care in a special care unit, and the remaining days he receives care in a routine area. The operating costs per day in such a case would typically be highest on the first day and lowest on the last day. For this example, assume that the operating costs on Day 1 = $1,000; Day 2 = $600; Day 3 = $400; Day 4 = $350; Day 5 = $350; Day 6 = $300. These assumptions yield an

operating cost per case of $3,000 and an average cost per day of $500. Assume further that the average length of stay declines by one day. Lastly, as is common, that the decrease in the length of stay is caused by the patient being discharged earlier. Using the Virginia Medicaid appeal regulations assumption that 60% of operating costs are variable and 40% are fixed, the need for downward adjustment in the cost per case and an upward adjustment in the cost per day inflator becomes apparent. Under the per case system, the hospital would arguably save the variable operating costs incurred on the last day, some $180. Thus, the cost to the hospital is not $3,000, but may be as low as $2,820. The hospital under a per case payment has a potential profit or productivity benefit of $180 if changes in length of stay are not factored into the "update factor". Under the per diem system which pays the average cost of $500, the hospital is paid for five days for a total of $2500. The hospital has at least a $320 loss assuming it can avoid all variable costs for the last day. Though simplistic, this example, in large part, explains one of the basic defects of the Virginia Medicaid prospective payment system.

14. Medicaid allowable costs do not represent "all costs expended by . . . hospitals in all 'allowable' categories defined by Medicare", as stated in Mr. Sorrell's affidavit. Hospitals may only claim allowable costs which are reasonable and necessary to patient care. If costs claimed do not meet this standard, they would not be allowed by Medicare.

15. Medicaid does represent about 5.4% of hospital revenues and patient days in Virginia. Based upon DMAS' Revised Data for 1986, DMAS reimbursement

levels were $29,233,350 below Medicaid hospital allowable costs in 1986. However, if Medicaid rates were paid by all payors, Virginia hospitals would have incurred approximately $520,000,000 in unreimbursed, Medicaid allowable, operating costs. They would have to cover these costs out of their existing reserves. Needless to say, such losses would have been devastating to the health care system in Virginia.

16. The Final Regulations For Hospital Appeals Of Reimbursement Rates ("Appeal Regulations") prohibit appeal of the systemic defects in the DMAS prospective payment system. *See* Appeal Regulations Section 1.C. Additionally, to obtain relief, a hospital must demonstrate that its operating costs in excess of its payment rate are generated "by factors not generally shared by other hospitals in its peer group." *See* Appeal Regulations Section 4.C.2. The Appeals Regulations also condition relief upon a financial jeopardy analysis. *See* Appeals Regulations Section 4.D.1. First, a hospital must show it has a marginal loss, i.e., that its Medicaid rate is insufficient to pay 60% of its operating costs. Alternatively, a hospital without a marginal loss may obtain relief if it has "unique and compelling Medicaid costs, which if unreimbursed by Medicaid, would clearly jeopardize the hospitals' long-term financial viability". Again, because the factors causing a hospital to exceed its Medicaid payment rate are generally common to all hospitals, such cost will not be "unique".

/s/ Joseph Becht
Joseph Becht

Subscribed and sworn to before me this 18th day of March, 1988.

/s/ Ruth Ann Toney
Notary Public

My Commission expires: October 6, 1988

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF VIRGINIA Richmond Division

THE VIRGINIA HOSPITAL ASSOCIATION, Plaintiff,	CIVIL ACTION NO. 86-1066-R
v.	(Filed Mar. 25, 1988)
GERALD L. BALILES, *et al.*, Defendants.	

ORDER

Deeming it just and proper so to do, it is ADJUDGED and ORDERED that defendant's motion to dismiss or for summary judgment be, and hereby is, DENIED.

Let the Clerk send a copy of this order to all counsel of record.

/s/ Robert R. Merhige, Jr.
UNITED STATES
DISTRICT JUDGE

Date MAR 25 1988